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Office of Administrative Law Judges
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Issue Date: 13 March 2003

CASE NUMBER: 2002-LHC-1734

OWCP NO.: 07-158296

IN THE MATTER OF

GEORGE BOOKER,
Claimant

v.

BOH BROTHERS CONSTRUCTION,
Employer

and

NATIONAL UNION AND FIRE INS. CO.,
Carrier

APPEARANCES:

Arthur J. Brewster, Esq.
On behalf of Claimant

Marc Moroux, Esq.
On behalf of Employer

Before: Clement J. Kennington
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (the Act), 33 U.S.C. § 901, *et seq.*, brought by George Booker (Claimant), against Boh Brothers Construction Co. (Employer) and National Union Fire Ins. Co. (Carrier). The issues raised by the parties could not be resolved administratively, and the matter was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held on December 11 2002, in Metairie, Louisiana.

At the hearing all parties were afforded the opportunity to adduce testimony, offer documentary evidence, and submit post-hearing briefs in support of their positions. Claimant testified and introduced five exhibits, which were admitted, including: the medical records and deposition of Dr. Alan Hinton; the deposition of Dr. Reynard Odenheimer; and the medical records of Dr. Clark Gunderson.[1] Employer introduced three exhibits, which were admitted, including: the medical records and deposition of Dr. Alan Sconzert.

Post-hearing briefs were filed by the parties. Based upon the stipulations of the parties, the evidence introduced, my observation of the witness demeanor and the arguments presented, I make the following findings of fact, conclusions of law, and Order.

I. STIPULATIONS

At the commencement of the hearing the parties stipulated and I find:

1. The injury/accident occurred on July 7, 2000;

2. Claimant was injured in the course and scope of employment and an employer-employee relationship existed at the time of the accident;

3. Employer was advised of the injury on July 10, 2000;

4. An informal conference was held on March 19, 2002;

5. Claimant's average weekly wage at the time of the injury was $498.90;

6. Claimant received benefits as follows:

> Temporary total disability - July 13, 2000 to July 21, 2001
> Scheduled disability from July 13, 2000 to November 27, 2002
> Total compensation benefits received: 124 weeks at $332.66 per week for a total of $41,242.40[2]
> Total medical benefits paid: $32,507.82; and

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[1] References to the transcript and exhibits are as follows: trial transcript- Tr.__; Claimant's Exhibits- CX __, p.__; Employer Exhibits- EX __, p.__; Administrative Law Judge Exhibits- ALJX __, p.___.

[2] In Employer's post-hearing memorandum, Employer noted the stipulation regarding the total payments of benefits was inaccurate. Employer asserts that it paid temporary total disability benefits from July 13, 2000 through the present (136 weeks) at $322.66 per week for a total of $45,241.76. Employer also stated that it continues to pay disability benefits pending a decision by this Court.

7. Claimant has a permanent partial disability of 20% to his leg.

II. ISSUES

The following unresolved issues were presented by the parties:

1. Relation of current medical condition, treatment, and diagnostic recommendations to the accident;

2. Entitlement to medical treatment, including, but not limited to, a MRI of the lumbar spine and a EMG of the lower extremity;

3. Nature and extent of disability;

4. Date of maximum medical improvement; and

5. Penalties, interest, and attorney's fees.

III. STATEMENT OF THE CASE

A. Chronology

Claimant is a forty-seven year old high school graduate who resides in Lake Charles, Louisiana. Claimant worked heavy construction for approximately twenty years, holding various jobs, and worked for Employer on and off for five to six years prior to his injury. (Tr. 13-14, 51). On July 7, 2000, Claimant was constructing a docking platform at the Port of Lake Charles, and while walking over unsecured wooden forms used for pouring concrete - he slipped and fell a short distance into the water - hitting his right knee against a three by eight board. (Tr. 15-16). Following his injury, Claimant used crutches and performed light duty work for Employer. (Tr. 52). Shortly thereafter, Claimant was terminated when he tested positive for cocaine. (Tr. 52-53).

On July 17, 2000, Dr. Cohen diagnosed Claimant with a contusion to the knee but opined Claimant could resume light duty work. (CX 2, p. 32-33). A subsequent MRI and EMG of Claimant's knee, however, demonstrated the need for surgery and Dr. Hinton, on orthopaedist, performed arthroscopic surgery on October 31, 2000 to repair a complex tear to the medical meniscus. *Id*. at 21. Claimant seemed to heal slowly after the surgery, but by January 8, 2001, Dr. Hinton remarked that Claimant had reached maximum medical improvement with regards to his knee surgery. *Id*. at 37-38.

Unfortunately, Claimant continued to present symptoms of an injury. Claimant had diffuse numbness and a saphenous nerve injury for which Dr. Hinton referred Claimant to Drs. Sconzert and

Odenheimer. Dr. Sconzert opined on February 2, 2001, that Claimant could return to work at full duty, (EX 2, p. 10), but Claimant continued to complain of pain symptoms and by June 19, 2001, Dr. Odenheimer assessed a foot drop, among other problems, and issued a "no work" slip on July 24, 2001. (CX 3, p. 14, 74). In addition to a foot drop, Dr. Odenheimer also assessed complex regional pain syndrome. (CX 3, p. 39; CX 4, p. 27). Furthermore, Claimant began to experience back problems which Drs. Hinton and Odenheimer attributed to an altered gait. (CX 1, p. 42; CX 3, p. 26). The onset of back problems, the diagnosis of complex regional pain syndrome, and the lack of a satisfactory explanation for Claimant's foot drop led Drs. Hinton and Odenheimer to request a lumbar MRI, which Employer denied. (CX 1, p. 37-38; CX 3, p. 37). Dr. Odenheimer also recommended an updated EMG to help assess Claimant's reports of sciatica and radiculopathy, which Employer also denied. (CX 3, p. 38-39).

Meanwhile, Claimant's foot drop made it difficult for him to operate a motor vehicle, and in October 2001, Claimant was involved in an automobile accident. (CX 3, p. 70). To remedy the problem Dr. Odenheimer prescribed handicap driving hand controls. *Id*. In July 2002, Claimant was involved in another automobile accident when the bus he was riding on was struck by a another vehicle. (Tr. 41-42). Finally, Claimant suffered a heart attack after his workplace accident, but Claimant admitted his heart condition was not unrelated to his workplace injury. (Tr. 43).

B. Claimant's Testimony

Claimant testified that he worked for Employer periodically for five to six years prior to his accident. (Tr. 13). Working for Employer and other construction industry firms, Claimant held positions as a boiler-maker, pipe-fitter, electrical laborer, construction laborer, and as a maintenance personnel. (Tr. 14). After high school, Claimant attended Electronic Computer Programming Institute and spent fourteen to fifteen months in Houston, Texas working for Texas Commerce Bank as a teller's assistant and he also worked for a securities firm called Rotan Mosley. (Tr. 48). Additionally, Claimant served three years in the National Guard as a helicopter crew chief mechanic. (Tr. 49). In total, Claimant estimated that he worked heavy construction for twenty years. (Tr. 51).

In July 2000, Claimant was working for Employer constructing a docking platform at the port of Lake Charles. (Tr. 14). Claimant explained the occurrence of his injury:

> I was removing the jacks that hold up for the concrete. We was pouring concrete for the - - to make the bridge. We take out the forms, removing forms - - it's mostly like carpentry, all the wood and the jacks was holding it. We take the jacks out and we're walking across these two by twelves, with the jacks. That's not nailed down, they just slant across - - just sittin' up across the beams that's - - the little beams on the platform. . . . And just slide, it slid back from up under me. . . . When the board slipped, out from under me . . . I fell from an angle, from about five foot to six foot angle. Well coming down, I hit the water. Even with the water is a

> three by eight. The corner of it - - one side hit - - the impact was on the left side of my knee - - my right knee.

(Tr. 15-16).

When Claimant fell, he testified that he also hit his back, but he did not experience back pain at the time of the injury and his back was not swollen.[3] (Tr. 23). Claimant suffered the injury late on Friday afternoon and he obtained a ride to the hospital emergency room with a co-worker. (Tr. 22). At the hospital Claimant's knee had swollen to such an extent that hospital staff had to cut his pant leg before administering shots for his pain. (Tr. 22-23). Eventually, Claimant chose an orthopaedist, Dr. Gunderson, who referred Claimant to Dr. Hinton for knee surgery. (Tr. 26).

Following his injury, Employer offered Claimant a light duty position but Claimant stopped working after a few weeks because Claimant tested positive for cocaine use in an employment drug screening test. (Tr. 52). After having knee surgery in October 2000, Claimant related that he attended all of his physical therapy sessions and Dr. Hinton's observation that Claimant missed ten of thirteen sessions was inaccurate. (Tr. 64).

As a result of his injury, Claimant testified that he experienced shooting pains in his leg that prevented him from sitting down for long periods of time. (Tr. 32). The pain not only shot down into his shin, but it also shot up into his lower back. (Tr. 33). Following his knee surgery, Claimant testified that he still experienced some swelling in his knee and he needed crutches to move about. (Tr. 35). Claimant also developed a foot drop while treating with Dr. Hinton and he used an AFO brace to keep from tripping. (Tr. 38). The foot drop also inhibited his ability to drive to such an extent that he sustained an auto accident, but he testified that he did not sustain any injuries. (Tr. 38-39). To be able to drive effectively, Claimant needed hand controls as prescribed by Dr. Odenheimer, but Carrier had not yet provided those to him. (Tr. 39).

Claimant also suffered an intervening injury while riding the city bus. (Tr. 41-42). Furthermore, Claimant related that he had a heart attack and underwent heart surgery for which he is currently receiving medical attention. (Tr. 43). Claimant admitted that his heart condition was totally unrelated to his workplace accident. (Tr. 43).

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[3] Claimant did not mention that he suffered any back pain to Dr. Gunderson and never mentioned in a January 2001 deposition that he hit his back. (Tr. 57-58, 60). Claimant testified that he spoke with Dr. Hinton about having back pains but did not consider them to be a major problem next to his knee. (Tr. 44-45).

C. Exhibits

C(1) Medical Records and Deposition of Dr. Alan Hinton

On July 17, 2000, Dr. Cohen evaluated Claimant for right knee pain. (CX 2, p. 32). Dr. Cohen noted that Claimant's knee was very sensitive and he had a guarded range of motion, but Claimant did not exhibit ascertainable signs of instability. *Id*. X-rays were unremarkable and Dr. Cohen diagnosed a contusion to Claimant's right knee. *Id*. at 33. Dr. Cohen recommended aggressive physical therapy because he opined Claimant's symptoms outweighed his signs. *Id*. It was unlikely that Claimant sustained any internal derangement to his knee, but if Claimant did not improve through physical therapy, then Dr. Cohen recommended an MRI. *Id*. Meanwhile, Dr. Cohen opined that Claimant could return to light duty work.

An August 8, 2000 MRI of the right knee demonstrated a tear of the posterior horn of the medial meniscus. (CX 2, p. 28). An October 2, 2000 EMG revealed: a low amplitude right saphenous sensory nerve conduction study consistent with an incomplete right saphenous sensory neuropathy; and there was no electro-physical evidence of a more proximal fomoral neuropathy, right lumbosacral radiculopathy or a more diffuse polynucuropathy affecting the right lower limb. *Id*. at 27. Reviewing the results with Claimant on October 23, 2000, Dr. Hinton stated that Claimant's symptoms were consistent with a meniscal tear. *Id*. at 25. Dr. Hinton also opined Claimant had a saphenous nerve injury. (CX 1, p. 12). The saphenous nerve ran from the groin to the ankle, was not related to any nerve roots in the spinal cord, and was not disabling. *Id*. After consultation, Claimant elected to undergo arthroscopic surgery in an effort to return to work as soon as possible. (CX 2, p. 25). Dr. Hinton performed that surgery on October 31, 2000, and his post-operative diagnosis was: complex tear to the medial meniscus, chondromalacia grade 2/4 of the medial femoral condyle, chrondromalacia grade 2/4 of the patella, and multiple loose body formations. *Id*. at 21. On November 1, 2000, Dr. Hinton started Claimant on physical therapy and instructed Claimant on how to discontinue the use of crutches. *Id*. at 16.

On January 8, 2001, Dr. Hinton reported Claimant had a full range of motion, no effusion, and a well healed surgical incision. (CX 2, p. 14). Claimant did have a diffuse numbness pattern and Dr. Hinton recommended an evaluation by a neurologist. *Id*. Dr. Hinton opined that Claimant was doing okay in his post-operative course, an in his examination he did not note any limping or walking with an antalgic gate. (CX 1, p. 19-20).

Summarizing a meeting with Dr. Hinton, a representative of Carrier, reported that as of January 8, 2001, Claimant had reached maximum medical improvement with a fifteen percent permanent impairment rating to the right lower extremity and a seven percent impairment rating to the body as a whole. (CX 2, p. 37-38). Regarding Claimant's complaint of numbness, Dr. Hinton stated it was diffuse, meaning that it did not follow any particular nerve root dermatome pattern. (CX 1, p. 20). Dr. Hinton referred Claimant to Dr. A. Sconzert to treat Claimant for a saphenous nerve injury, and he deferred to Dr. Sconzert on Claimant's ability to return to work. *Id*.

On March 9, 2001, Dr. Hinton noted that Claimant was having problems with numbness in his foot, and he was complaining of episodes of instability, catching, and locking of his knee. (CX 2, p. 11). Dr. Hinton again recommended Claimant see a neurologist to treat him for a saphenous nerve injury, and he released Claimant to return only when Claimant felt necessary. *Id*. Claimant returned on April 16, 2001, continuing to complain of pain, but he refused Dr. Hinton's recommendation for aspiration of the knee. *Id*. at 10. Aspiration was merely removing fluid from the knee and it may have reduced Claimant's pain complaints and improved his level of functioning. (CX 1, p. 24).

On June 18, 2001, Claimant again complained to Dr. Hinton of foot and ankle pain, and a burning sensation due to his nerve injury. (CX 2, p. 9). Claimant demonstrated mild swelling and pain on palpation in his physical exam, and Dr. Hinton recommended Claimant have a bone scan. *Id*. at 9. When Claimant returned with the same complaints on July 27, 2001, Dr. Hinton told Claimant not to return to work until his next appointment. *Id*. at 7-8.

Claimant's August 2, 2001 bone scan revealed increased radioniclide uptake within the right knee in multiple locations when compared to the left. (CX 2, p. 6). Reviewing the results on August 8, 2001, Dr. Hinton remarked the findings were consistent with degenerative joint disease or with reflex sympathetic dystrophy (RSD). *Id*. at 5. RSD is a neurologic problem occurring after an injury that leaves a person with hard to explain persistent pain. (CX 1, p. 27). Dr. Hinton recommended Claimant follow up with Dr. Odenheimer who had fitted Claimant for a foot drop splint. (CX 2, p. 5). Dr. Hinton did not think Claimant demonstrated a foot drop as he had some strength. *Id*. Claimant was, however, a good candidate for a pain management referral. *Id*. Dr. Hinton further opined that it was very unusual for a patient to have a "hot" bone scan following meniscal surgery. (CX 1, p. 50).

In an August 20, 2001 meeting with Carrier's representative, Dr. Hinton opined that Claimant's bone scan demonstrated findings consistent with RSD and that RSD was a contributing factor to Claimant's foot drop. (CX 2, p. 35-36). To further investigate the problem, Dr. Hinton ordered an MRI of the lumbar spine and right knee. *Id*. at 36. The MRI of the lumbar spine was necessary because Dr. Hinton wanted to make sure there was no structural problem that was causing Claimant's nerve symptoms. (CX 1, p. 31-32). Dr. Hinton did not want the MRI to solely look at trauma related findings, because other factors such as weakness, tumors, or sclerosis could cause Claimant's pain problems. *Id*. at 32. Considering Claimant's lack of lumbar complaints to Dr. Hinton, he opined that any pain connection to Claimant's lumbar spine would be disease related but without the test he could not be sure. *Id*. at 32-33. While Claimant's arthritis would cause some of his symptoms, it would not account for the degree of his pain. *Id*. at 35. From an orthopaedic standpoint, Hinton related he had nothing further to offer Claimant. *Id*. at 36.

A MRI of Claimant's right knee taken on August 21, 2001 demonstrated: a tear of the posterior horn of the medial meniscus with extension to the superior meniscal surface, and small joint effusion, but the results were otherwise normal. (CX 2, p. 3). Reviewing the findings with Claimant on August 24, 2001, Dr. Hinton reported he had nothing to further offer, and Claimant should see

both a neurologist and a pain management specialist. *Id*. at 2. Dr. Hinton's impression was that Claimant suffered from arthritis in the knee and some reflex sympathetic dystrophy. *Id*. A year later, on August 21, 2002, Dr. Hinton reevaluated Claimant noting he continued to complain of knee pain. *Id*. at 1. Dr. Odenheimer was treating Claimant for a back and spinal condition and Dr. Hinton concurred that Claimant should obtain an MRI of his lumbar spine. *Id*. Dr. Hinton also noted that Claimant complained of a pain pattern which did not correlate to any pain or dermatomal pattern he was familiar with. (CX 1, p. 37).

On August 12, 2002, Dr. Hinton met with Carrier's representative to explain the need for a lumbar MRI and to discuss Claimant's permanent impairment. (CX 1, p. 37-38). At that meeting, Dr. Hinton assessed a twenty percent permanent partial disability rating to the leg which equated to a nine percent impairment to the whole body. *Id*. at 38. Claimant's impairment rating had increased because he has some atrophy in his legs and his muscles were smaller. *Id*. at 44. Dr. Hinton did not assign any work restrictions for Claimant's knee. *Id*. at 44-45. At that time Claimant had no mechanical restrictions to his knee as a result of his injury and Dr. Hinton did not recommend further surgery. *Id*.

In his October 7, 2002 deposition, Dr. Hinton related that Claimant never complained of any low neck pain. (CX 1, p. 8). Claimant also had arthritic changes in his knee, but Dr. Hinton stated those were due to long standing wear and tear and were not caused by any traumatic event. *Id*. at 15. While Claimant's injury did not cause his arthritis, Dr. Hinton opined that Claimant's traumatic injury did aggravate his arthritic problems. *Id*. at 46. Regarding the fact that Claimant missed numerous physical therapy secessions following his surgery, Dr. Hinton stated Claimant's refusal to cooperate could hinder his recovery process, prolong his disability status, and result in a greater permanent disability. *Id*. at 18. Dr. Hinton related that the normal healing period for a meniscal injury ranged from three to six weeks, and Claimant's recovery period fell far outside that norm. *Id*. at 38-39.

Dr. Hinton explained that Claimant's back problems could have develop as a result of Claimant's altered gait problems, which he traced to a twisted ankle in June 2001. (CX 1, p. 42). Using crutches, a cane, and wearing a foot brace were all factors that could cause changes in a person's gait, but in general, Dr. Hinton explained it took a long time for back problems to arise in connection with an abnormal gait.. *Id*. at 43, 53. Given the fact that Claimant did not have a compete neurological work up, a lumber MRI, or pain management treatment, Dr. Hinton opined Claimant had not reached maximum medical improvement with regards to his right lower extremity even though he had reached maximum medical improvement with regards to his knee surgery. *Id*. at 56. A neurologist should make the determination if Claimant's lower extremity had reached maximum medical improvement after the appropriate work-up. *Id*. at 56.

C(2) Medical Records of Dr. Clark Gunderson

On August 9, 2000, Claimant reported in Dr. Gunderson's pre-examination questionnaire that he had pain, swelling, and numbness in the right leg. (CX 5, p.1). Dr. Gunderson prescribed knee rehabilitation. *Id*. at 5. In an Advanced Rehab Services note dated August 31, 2000, physical therapist

Dwaine Miller reported Claimant continued to complain of left and right knee pains. *Id*. at 16. Claimant was only able to tolerate minimal resistance through his right knee and his tolerance for activity was significantly decreased. *Id*. Overall, Claimant complained of pain and decreased functional tolerance with no significant improvement noted in rehabilitation. *Id*.

C(3) Medical Records and Deposition of Dr. Alan Sconzert

In an October 2, 2000 evaluation, Claimant complained to Dr. Sconzert, a neurologist, of numbness in his right leg below the knee cap that extended to his ankle. (EX 3, p. 4). In observing Claimant's gait, Dr. Sconzert noted feigned limping on the right, but Claimant's EMG test provided a physiological reason for that limp. *Id*. at 4; (EX 1, p. 12-13). Based on Claimant's EMG, Dr. Sconzert opined Claimant's prognosis was good and he noted that Claimant was not in need of surgical repair. (EX 3, p. 4).

Claimant's EMG only showed an injury to the nerve and not the muscles. (EX 1, p. 12). Dr. Sconzert did not note any foot drop. *Id*. Dr. Sconzert further opined that in a typical case, a patient would recover from a saphenous nerve injury and have an essentially normal gait, but sometimes in adapting to the pain the patient could alter their gait. *Id*. at 13-14. Dr. Sconzert fully expected Claimant to return to full functioning without any disability. *Id*. at 14-15.

On January 18, 2001, Claimant reported numbness, tingling, pain, and minor paralysis of his right lower extremity at the bottom of his leg and foot. (EX 3, p. 1). Claimant also reported right foot swelling, and knee pain when he held his leg straight. *Id*. Dr. Sconzert noted guarding of the right leg and some exaggerated pain responses. *Id*. Plantar stimulation resulted in a down-going toe. *Id*. Dr. Sconzert opined Claimant had a right saphenous nerve injury secondary to trauma. *Id*.

In a February 2, 2001 response to an inquiry by Carrier, Dr. Sconzert noted Claimant could return to work at full capacity without restrictions. (EX 2, p. 10). Dr. Sconzert did not know when Claimant would reach maximum medical improvement. *Id*.

Dr. Sconzert explained that a foot drop could be caused by problems in the L4-5 distribution of the lumbar spine. (EX 1, p. 25). Typical problems causing foot drop were herniated discs, neurosyphilis, or a tumor. *Id*. at 25-26. While nerve root irritation would not likely cause a foot drop, it could be caused by entrapment of the nerve. *Id*. at 26. Dr. Sconzert also opined that a lumbar caused foot drop would be detectable on the EMG because it would pick up the muscle stimulation but not the nerve involvement. *Id*. at 27. Regarding Dr. Odenheimer's assessment of a foot drop, Dr. Sconzert remarked that he expected any nerve damage from Claimant's July, 2002, injury would have developed by the date of his January examination, but people heal at different rates and Claimant could have developed scar tissue that impeded his nerve. *Id*. at 19. At the time of his January evaluation, Dr. Sconzert was unaware that Claimant had orthoscopic surgery in October. *Id*. at 22.

C(4) Medical Records and Deposition of Dr. Reynard C. Odenheimer

On June 19, 2001, Dr. Odenheimer, a neurologist, evaluated Claimant on the referral from Dr. Hinton. (CX 3, p. 74). In his examination, Claimant demonstrated some weakness in dorsiflexion of the right foot and toes, Claimant limped slightly with a subtle foot drop on the right, and he had decreased sensation to anterolateral right leg. *Id*. at 75. Dr. Odenheimer's initial impression was: leg pain, neuralgia, possible dystonia, sensory disturbance, sleep disturbance, weakness, situational depression, knee pain/trauma. *Id*. Dr. Odenheimer recommended various prescription medications. *Id*. The decreased sensation to the anterolateral right leg could be caused by either the peroneal, sciatic, or lumbar nerves. (CX 4, p. 8).

On a July 17, 2001, Claimant continued to complain of pain, right foot weakness, and electrical shock sensations whenever he bumped his leg. (CX 3, p. 13-14). On July 24, 2001, Dr. Odenheimer gave Claimant a "no work" slip. *Id*. at 14. During his September 18, 2001 examination, Claimant told Dr. Odenheimer for the first time that he was experiencing right low back pain with walking and was using a cane. *Id*. at 16. Claimant specifically related his back pain to his walking limitations and Dr. Odenheimer ordered an MRI of Claimant's lumbar spine to assist in evaluation and considered ordering a functional capacity evaluation. *Id*. at 16-17. Dr. Odenheimer opined that persons with injuries to their lower extremities could develop back pain if their gait was disturbed due to injury. *Id*. at 19. Dr. Odenheimer did not perform any examination of Claimant's back during the visit and his diagnosis of back pain was based solely on Claimant's complaints. (CX 4, p. 11).

Regarding Claimant's foot drop, Dr. Odenheimer noted that the symptom was usually associated with a nerve injury near the knee, but it could also be caused by a problem with the back and nerves extending from the lumbar spine. *Id*. at 17. Claimant's foot drop represented a muscular weakness, which was a result of an injury to the peroneal nerve. (CX 4, p. 6). Claimant's October, 2000 EMG, however, did not show any damage to the peroneal nerve. *Id*. at 7. Dr. Odenheimer stated that he expected a foot drop syndrome to appear shortly after the injury which produced it, and going several months without any symptoms would cause Dr. Odenheimer to hesitate in connecting Claimant's foot drop to his injury. *Id*. at 9. Nonetheless, Dr. Odenheimer opined Claimant's injury was not the only trauma to his leg - surgical intervention - and subsequent healing and splintering could also cause the problem. *Id*.

Regarding Dr. Hinton's diagnosis of a right saphenous nerve injury, Dr. Odenheimer related that the diagnosis would explain some of Claimant's pain complaints. (CX 3, p. 18). The saphenous nerve served a sensory function connected to the leg and calf, and while the disturbance of that nerve caused pain, it would not explain Claimant's foot drop. *Id*.

On October 24, 2001, Claimant related to Dr. Odenheimer that he had recently tried to drive but was in a motor vehicle accident because he was not able to fully control his right foot. (CX 3, p. 20). To remedy the problem, Dr. Odenheimer recommended handicap hand controls for Claimants' vehicle. *Id*. at 21. While Dr. Odenheimer no longer felt that dystonia was a problem, he did assess back spasm based solely on Claimant's complaints. *Id*. at 20. Dr. Odenheimer suggested

a comprehensive evaluation at New Day Rehab facility and issued a letter to Claimant stating that he felt Claimant was disabled. *Id*. at 21. Dr. Odenheimer declined to give a disability rating because he did not feel qualified to perform such tasks. *Id*. at 12.

After undergoing a functional capacity evaluation, Claimant related to Dr. Odenheimer on November 21, 2001, that he was experiencing head aches, poor sleep, burning sensations in his right calf, spasm in the foot and toes, and pain and swelling in his right leg that had been exacerbated by his functional capacity evaluation. (CX 3, p. 21). Spasm in the foot and toes was not likely a result of a saphenous nerve injury, but was related to a peripheral nerve. *Id*. at 22. Dr. Odenheimer did not recommend any tests regarding foot and toe spasms, other than the lumbar MRI he had already requested. *Id*. While the MRI would assist in determining whether the spine was involved in creating foot spasms, that symptom was not surprising to Dr. Odenheimer considering Claimant's leg injury and other nerve involvements. *Id*. Dr. Odenheimer was not able to detect any foot and toe spasm, swelling in Claimant's leg, or back spasms himself, and Claimant did not complain of back pain on that visit. (CX 4, p. 12).

By December 2001, Claimant related he had hip pain that started when he began using a cane. (CX 3, p. 23). Dr. Odenheimer's impression was unchanged, and he referred Claimant to pain management. *Id*. at 24. On February 21, 2002, Dr. Odenheimer reiterated his request for an MRI. *Id*. at 25. He could not say with certainty whether Claimant's symptoms were related to the lumbar spine. *Id*. Claimant's symptoms were likely due to his knee injury based on the fact that the foot drop followed his knee injury and the back pain came later. *Id*. at 26. An MRI would help to rule one cause out more definitively. *Id*. On his February 21, 2002 visit, Dr. Odenheimer did not note any hip pain. (CX 4, p. 15).

On March 27, 2002, Claimant presented with complaints of right hip, leg and thigh pain. (CX 3, p. 26). Significantly, Claimant's symptoms were moving up the leg suggesting Claimant's altered gait may be affecting his back. *Id*. Dr. Odenheimer's two new impressions were gait disturbances due to leg injury and sciatica secondary to gait change. *Id*. An MRI would also help to explain if there was any nerve root involvement to explain sciatica. *Id*. at 26-27. Dr. Odenheimer reaffirmed that Claimant was unable to return to his previous employment and Dr. Odenheimer encouraged vocational rehabilitation. *Id*. at 27. Specific restrictions would in accordance with Claimant's functional capacity evaluation and the limitations set by Claimant's orthopaedist. *Id*. Based on Claimant's medications, Dr. Odenheimer did not recommend that Claimant operate any machinery or equipment. *Id*. at 29. In a May 23, 2002 evaluation, Dr. Odenheimer assessed chronic pain syndrome and reported that Claimant still could not return to his previous employment. *Id*. at 31. In July 2002, Claimant continued to report consistent radicular symptoms, but now Claimant was also reporting right buttock pain. *Id*. at 32. Dr. Odenheimer assessed suspect lumbar radiculopathy possibly secondary to a gait disturbance or leg injury. *Id*. at 33. Also in July 2002, Claimant reported he suffered injuries in a motor vehicle accident, but Dr. Odenheimer noted that Claimant's symptoms of low back radiating pain, sciatica, cramping, and foot spasm all predated the motor vehicle accident. *Id*. at 32-33.

Given Claimant's condition on July 25, 2002, he did not feel that Claimant was capable of light duty work during an eight hour day. (CX 3, p. 35). On October 9, 2002, Claimant continued to have difficulty after suffering his motor vehicle accident, and specifically complained of neck pain related to that injury. *Id*.

Because Claimant did not have a MRI of his lumbar spine, Dr. Odenheimer was unable to reach a definitive diagnosis with regard to the cause of Claimant's foot drop. (CX 3, p. 37). Dr. Odenheimer also opined an EMG nerve conduction study of the lower extremity would be helpful in assessing Claimant's condition. *Id*. Regarding Claimants' October 2, 2000 EMG documenting a right saphenous nerve injury, Dr. Odenheimer related that Claimant did not complain of sciatic or radicular symptoms until several visits after he began treatment, which was long after the EMG was performed. *Id*. at 38. Given Claimant's new complaints of sciatica and radiculopathy, Dr. Odenheimer recommended an updated EMG. *Id*. at 39.

Regarding Dr. Hinton's assessment of RSD, Dr. Odenheimer explained it was a difficult entity to confirm and non-specific in many aspects. (CX 3, p. 39). While Dr. Odenheimer did not feel comfortable with diagnosing Claimant with RSD, Dr. Odenheimer was confident that Claimant had complex regional pain syndrome. (CX 3, p. 39; CX 4, p. 27). An EMG and a MRI would certainly assist in determining whether there was objective criteria to assist with the anatomic localization of nerve pathology to rule out complex regional pain syndrome. (CX 3, p. 39). Dr. Odenheimer believed that all of Claimant's current complaints (excluding his neck injury) were ultimately related to Claimant's initial knee injury. *Id*. at 39-40. Dr. Odenheimer had not observed any symptom magnification or malingering. *Id*. at 41. Claimant's work restrictions were continuing, and assessing a date for maximum medical improvement was impossible until he could assess whether Claimant's back was a contributing factor to his problems. *Id*. at 42.

Regarding his remark in February, 2002, to Carrier's representative that Claimant had reached maximum medical improvement, Dr. Odenheimer stated it was a premature statement and made in connection with referring Claimant to vocational rehabilitation. (CX 3, p. 43). Specifically, Carrier asked Dr. Odenheimer: "Is it your opinion that Mr. Booker has reached MMI and can now be assessed for job placement based on the restrictions and guidelines noted in the FCE?" *Id*. at 59. In a handwritten note, Dr. Odenheimer replied: "I think this is probably the case." *Id*. Dr. Odenheimer believed Claimant's foot drop was likely permanent, he did not know if Claimant had the potential for improvement, and did not know whether his physical restrictions were permanent. (CX 4, p. 17). Claimant may be at MMI, but if he had a back problem contributing to his current limitation, an MMI date may not come for a few years. *Id*. at 17-18. Based on his records, Dr. Odenheimer opined that Claimant had reached a plateau with respect to improvement of his condition and his course of treatment was basically static. *Id*. at 18.

IV. DISCUSSION

A. Contentions of the Parties

Claimant contends that he is entitled to an MRI of his lumbar spine based on the medical evidence and the recommendations of Drs. Hinton and Odenheimer and the absence of any medical testimony to rebut the recommendations of Claimant's treating physicians. Pursuant to the opinions of Drs. Odenheimer and Hinton, no determination may be made that Claimant has reached maximum medical improvement until the results of the lumbar MRI are reviewed. Claimant also argues that his back problems are causally related to his workplace injury because he suffered from an altered gait due to his work related knee injury and subsequent surgery. Claimant further asserts that he is entitled to hand controls for his motor vehicle that would allow him to drive safely considering his foot drop symptoms. Such controls were recommended by Dr. Odenheimer and no physician has disputed the reasonableness or necessity of such devices. Finally, Claimant contends that because he has not reached maximum medical improvement, his condition is temporary, and due to Claimant's physical condition as well as his numerous medications, he is totally disabled.

Employer contends that Claimant's foot drop symptom is not related to his workplace accident because it did not appear until eleven months after his workplace injury and Claimant's reports of back pain are not related to his workplace injury as they did not appear until fourteen months after his workplace injury. While Dr. Odenheimer related Claimant's back problems and sciatica to his foot drop, the foot drop could not have been related to Claimant's workplace accident because a October 2000 EMG did not demonstrate an injury to the peroneal nerve, and foot drop symptoms would likely appear within minutes or days of a traumatic injury. Furthermore, Employer contends Claimant's testimony regarding his back pain is not credible considering the numerous inconsistencies in the record. Because, Claimant's foot drop and back pain are not related to his workplace injury, Employer asserts that it is not responsible for authorizing further diagnostic testing, and Claimant reached maximum medical improvement with regards to his workplace injury on January 8, 2001 without any residual disability.

B. Causation of Claimant's Foot Drop and Back Problems

B(1) The Section 20(a) Presumption - Establishing a *Prima Facie* Case

Section 20 provides that "[i]n any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary - - (a) that the claim comes within the provisions of this Act." 33 U.S.C. § 920(a) (2002). To establish a *prima facie* claim for compensation, a claimant need not affirmatively establish a connection between work and harm. Rather, a claimant has the burden of establishing only that: (1) the claimant sustained a physical harm or pain; and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused, aggravated, or accelerated the harm or pain. *Port Cooper/T. Smith Stevedoring Co., Inc., v. Hunter*, 227 F.3d 285, 287 (5th Cir. 2000); *O'Kelly v. Department of the Army*, 34 BRBS 39, 40 (2000); *Kier v. Bethlehem Steel Corp.*, 16 BRBS 128, 129

(1984). Once this *prima facie* case is established, a presumption is created under Section 20(a) that the employee's injury or death arose out of employment. *Hunter*, 227 F.3d at 287. "[T]he mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer." *U.S. Industries/Federal Sheet Metal Inc., v. Director, OWCP*, 455 U.S. 608, 102 S. Ct. 1312, 71 L. Ed. 2d 495 (1982). *See also Bludworth Shipyard Inc., v. Lira*, 700 F.2d 1046, 1049 (5th Cir. 1983) (stating that a claimant must allege injury arising out of and in the course and scope of employment); *Devine v. Atlantic Container Lines*, 25 BRBS 15, 19 (1990) (finding the mere existence of an injury is insufficient to shift the burden of proof to the employer).

Here, Claimant testified that when he suffered his injury on July 7, 2000 he also hurt his back. (Tr. 23). Following surgery on October 31, 2000, Dr. Hinton detected foot numbness on March 9, 2001. (CX 2, p. 11). On June 19, 2001, Dr. Odenheimer detected a foot drop. (CX 3, p. 75). While Dr. Odenheimer was hesitant to connect Claimant's foot drop to his workplace accident, he opined that Claimant's accident was not the only trauma to Claimant's knee. (CX 4, p. 9). Rather, Claimant also had surgical intervention and subsequent healing and splintering that could cause the problem. *Id*. Both Drs. Odenheimer and Hinton opined that Claimant's back problems could be due to an altered gait which was caused in part by Claimant's foot drop. (CX 1, p. 42-43; CX 4, p. 11). Also contributing to Claimant's altered gait was the fact that Claimant used crutches following his knee surgery, used a cane, and wore a foot brace. (CX 1, p. 53). Accordingly, I find that Claimant presented sufficient evidence to establish that his foot drop and back pain are causally connected to his July 7, 2000 workplace accident.

B(2) Rebuttal of the Presumption

"Once the presumption in Section 20(a) is invoked, the burden shifts to the employer to rebut it through facts - not mere speculation - that the harm was not work-related." *Conoco, Inc. v. Director, OWCP*, 194 F.3d 684, 687-88 (5th Cir. 1999). Thus, once the presumption applies, the relevant inquiry is whether Employer has succeeded in establishing the lack of a causal nexus. *Gooden v. Director, OWCP*, 135 F.3d 1066, 1068 (5th Cir. 1998); *Bridier v. Alabama Dry Dock & Shipbuilding Corp.*, 29 BRBS 84, 89-90 (1995) (failing to rebut presumption through medical evidence that claimant suffered an prior, unquantifiable hearing loss); *Hampton v. Bethlehem Steel Corp.*, 24 BRBS 141, 144-45 (1990) (finding testimony of a discredited doctor insufficient to rebut the presumption); *Dower v. General Dynamics Corp.*, 14 BRBS 324, 326-28 (1981) (finding a physician's opinion based of a misreading of a medical table insufficient to rebut the presumption). The Fifth Circuit further elaborated:

> To rebut this presumption of causation, the employer was required to present *substantial evidence* that the injury was not caused by the employment. When an employer offers sufficient evidence to rebut the presumption - the kind of evidence a reasonable mind might accept as adequate to support a conclusion - only then is the presumption overcome; once the presumption is rebutted it no longer affects the outcome of the case.

Noble Drilling v. Drake, 795 F.2d 478, 481 (5th Cir. 1986) (emphasis in original). *See also, Conoco, Inc.*, 194 F.3d at 690 (stating that the hurdle is far lower than a "ruling out" standard); *Stevens v. Todd Pacific Shipyards Corp.*, 14 BRBS 626, 628 (1982), *aff'd mem.*, 722 F.2d 747 (9th Cir. 1983) (stating that the employer need only introduce medical testimony or other evidence controverting the existence of a causal relationship and need not necessarily prove another agency of causation to rebut the presumption of Section 20(a) of the Act); *Holmes v. Universal Maritime Serv. Corp.*, 29 BRBS 18, 20 (1995) (stating that the "unequivocal testimony of a physician that no relationship exists between the injury and claimant's employment is sufficient to rebut the presumption.").

In this case, Employer presented substantial evidence to rebut Claimant's *prima facie* case of causation. First, while Claimant testified that he hurt his back in his July 7, 2000 accident, Claimant never mentioned to Dr. Hinton or Gunderson that he suffered back injuries, and never mentioned in his January 2001 deposition that he suffered back pain. (Tr. 44-45, 57-58, 60). The record is devoid of any evidence outside of Claimant's contradicted testimony that Claimant suffered from back pain contemporaneous with his injury.

Second, following Claimant's October 31, 2000 knee surgery, Dr. Hinton noted that Claimant did okay post-operatively. (CX 1, p. 19). In his January 8, 2001 evaluation, Dr. Hinton did not detect any limp or antalgic gait. *Id*. at 20. It was not until March 9, 2001 that Claimant began to complain of numbness in his foot. (CX 2, p. 11). On June 19, 2001, Dr. Odenheimer assessed a foot drop, but he related that Claimant's foot drop was caused by an injury to the peroneal nerve, which was normal in an October 2000 EMG. (CX 4, p. 6-7). Furthermore, Dr. Odenheimer expected symptoms of a foot drop would appear shortly after the injury, and going several months without any symptoms would cause Dr. Odenheimer to hesitate in connecting Claimant's foot drop to his injury. *Id*. at 9. Likewise, Dr. Sconzert stated that he would have expected any symptoms of a foot drop to appear by the date of his last examination of Claimant on January 21, 2001. (EX 1, p. 19). Claimant's initial injury was on July 7, 2000, his surgery was October 31, 2000, and Dr. Hinton opined Claimant had reached maximum medical improvement in regards to his knee surgery by January 8, 2001. Over four months later, Dr. Odenheimer diagnosed Claimant's foot drop. Furthermore, Dr. Hinton opined on August 8, 2001, that Claimant did not really show evidence of a foot drop. (CX 2, p. 5). Additionally, while it is undisputed that Claimant suffered from a work related saphenous nerve injury, that injury would not explain Claimant's foot drop. (CX 3, p. 18).

Third, wearing a foot brace to control his foot drop contributed to Claimant's altered gait, a physical limitation which Drs. Odenheimer and Hinton related could cause Claimant's back problems. (CX 1, p. 42; CX 3, p. 16, 26). If Claimant's foot drop was not related to his workplace accident, then the subsequent aggravation of his back due to an altered gait would not likely be related to his workplace accident. Also, Dr. Hinton stated that back problems caused by an altered gait usually took a long time to develop, and Claimant's September, 2001, back complaints were approximately fourteen months after his workplace injury. (CX 1, p. 43). Accordingly, I find that Employer presented substantial evidence that Claimant's foot drop and back problems were not related to his workplace accident.

B(3) Causation on the Basis of the Record as a Whole

If the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. *Del Vecchio v. Bowers*, 296 U.S. 280, 286, 56 S. Ct. 190, 193, 80 L. Ed. 229 (1935); *Port Cooper/T Smith Stevedoring Co. v. Hunter*, 227 F.3d 285, 288 (5th Cir. 2000); *Holmes v. Universal Maritime Serv. Corp.*, 29 BRBS 18, 20 (1995). In such cases, I must weigh all of the evidence relevant to the causation issue. If the record evidence is evenly balanced, then the employer must prevail. *Director, OWCP v. Greenwich Colleries*, 512 U.S. 267, 281 (1994).

Based on the evidence as a whole, I find that Claimant's foot drop is causally related to his workplace injury. While there is no evidence of any foot drop symptoms immediately following Claimant's July 7, 2000, workplace accident, Dr. Odenheimer testified that Claimant's October 31, 2000 surgical intervention, and subsequent healing and splintering could cause a foot drop. (CX 4, p. 9). I also note that Dr. Sconzert opined that Claimant's foot drop could be caused by scar tissue resulting from Claimant's surgery, which could impede the nerves. (EX 1, p. 19). While Dr. Sconzert expected some scar tissue to have formed by his January 21, 2001 examination of Claimant, Dr. Sconzert opined that people heal at different rates.[4] Also, while Dr. Hinton never assessed a foot drop, he noted on March 9, 2001, that Claimant was "*still having* complaints of numbness in his foot,"[5] indicating that the symptom had been present at least since his last evaluation of Claimant on January 8, 2001. (CX 2, p. 11) (emphasis added). Accordingly, based on the lack of any intervening cause between Claimant's knee surgery and assessment of a foot drop, his slow pace of healing, the possibility that Claimant's foot drop could be caused by scar tissue, and the fact that Claimant likely reported foot drop symptoms as early as January 8, 2001, demonstrates by a preponderance of the evidence that Claimant's foot drop is causally connected to his workplace accident.

Similarly, I find Claimant's back problems (if any) are causally related to his workplace accident. Both Drs. Hinton and Odenheimer opined Claimant's back problems could be caused by an abnormal gait. (CX 1, p. 42; CX 3, p. 26). Also, rather than having an abnormal gait due solely to his foot drop symptoms, Claimant demonstrated a limp as early as October 2, 2000 in Dr. Sconzert's examination. (EX 3, p. 4). Reviewing Claimant's EMG test, Dr. Sconzert stated that Claimant had a physiological reason to limp. (EX 1, p. 12-13). Subsequently, Claimant underwent surgery, used crutches, was fitted with a foot brace, and used a cane to ambulate. While, Dr. Hinton reported that back problems due to an altered gait take some time to develop, Dr. Hinton never opined that the amount of time Claimant had an altered gait was insufficient to cause his back problems. (CX 1, p. 42-43). Accordingly, I find that a preponderance of the evidence demonstrates

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[4] Dr. Hinton noted that Claimants' recovery from his knee surgery fell far outside the normal three to six week recovery period. (CX 1, p. 38-39). Additionally, Dr. Hinton noted Claimant's absenteeism in post-surgery physical therapy could hinder his recovery process. *Id.* at 46.

[5] Foot numbness and weakness were symptoms which Dr. Odenheimer observed on June 19, 2001 that contributed to his findings of foot drop. (CX 3, p. 12, 74).

that Claimant's back problems are related to his workplace accident because that accident caused Claimant to suffer from an altered gait which caused low back irritation.

C. Reasonable and Necessity of a Lumbar MRI and a Lower Extremity EMG

Section 7(a) of the Act provides that "the employer shall furnish such medical, surgical, and other attendance or treatment . . . for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a) (2002). The Board has interpreted this provision to require an employer to pay all reasonable and necessary medical expenses arising from a workplace injury. *Dupre v. Cape Romaine Contractors, Inc.*, 23 BRBS 86 (1989). A claimant establishes a *prima facie* case when a qualified physician indicates that treatment is necessary for a work-related condition. *Romeike v. Kaiser Shipyards*, 22 BRBS 57, 60 (1989); *Pirozzi v. Todd Shipyards Corp.*, 21 BRBS 294, 296 (1988).

Here, both Drs. Hinton and Odenheimer recommended Claimant have a lumbar MRI to make sure that there was not any structural problem in Claimant's back that was causing Claimant's nerve symptoms. (CX 1, p. 31-32; CX 3, p. 22). An MRI would assist Dr. Odenheimer is making a definitive diagnosis with regard to the cause of Claimant's foot drop. (CX 3, p. 37). Also, given Claimant's new complaints of sciatica and radiculopathy, Dr. Odenheimer recommended an updated EMG because Claimant did not have those same complaints during his October, 2000, EMG. *Id*. at 39. As noted, *supra*, Section IV, Part B(3), Claimant's assessment of foot drop and back pain are probably related to his workplace injury based on existing evidence. Two of Claimant's treating physicians made specific recommendations for diagnostic testing, without contradiction, to better understand and treat Claimant's symptoms, thus, I find that a lumbar MRI and a EMG are both reasonable and necessary under the Act.

Additionally, I find that Claimant is entitled to hand control devises for driving his car. Claimant testified that his October, 2001, automobile accident, was due in part to the fact that he did not have adequate control over his right foot. (Tr. 38-39). Dr. Odenheimer made an uncontradicted recommendation to pursue handicap driving modifications. (CX 3, p. 70). Accordingly, I find that hand controls to allow Claimant to drive is a reasonable and necessary apparatus to accommodate Claimant's work related disability.

D. Nature and Extent of Disability and Date of Maximum Medical Improvement

Claimant seeks continuing temporary total disability benefits. Disability under the Act is defined as "incapacity because of injury to earn wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10) (2002). Disability is an economic concept based upon a medical foundation distinguished by either the nature (permanent or temporary) or the extent (total or partial). A permanent disability is one which has continued for a lengthy period and is of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649 (5th Cir. 1968); *Seidel v. General Dynamics Corp.*, 22 BRBS 403, 407 (1989); *Stevens v. Lockheed*

Shipbuilding Co., 22 BRBS 155, 157 (1989). The traditional approach for determining whether an injury is permanent or temporary is to ascertain the date of maximum medical improvement.

The determination of when maximum medical improvement is reached, so that a claimant's disability may be said to be permanent, is primarily a question of fact based on medical evidence. *Hite v. Dresser Guiberson Pumping*, 22 BRBS 87, 91 (1989). *Care v. Washington Metro Area Transit Authority*, 21 BRBS 248 (1988). An employee is considered permanently disabled if he has any residual disability after reaching MMI. *Lozada v. General Dynamics Corp.*, 903 F.2d 168 (2d Cir. 1990); *Sinclair v. United Food & Commercial Workers*, 13 BRBS 148 (1989); *Trask v. Lockheed Shipbuilding & Construction Co.*, 17 BRBS 56 (1985). A condition is permanent if a claimant is no longer undergoing treatment with a view towards improving his condition, *Leech v. Service Engineering Co.*, 15 BRBS 18 (1982), or if his condition has stabilized. *Lusby v. Washington Metropolitan Area Transit Authority*, 13 BRBS 446 (1981).

D(1) Nature of Claimant's Injury

On July 17, 2000, Dr. Cohen evaluated Claimant in relation to his right knee pain and diagnosed a contusion. (CX 2, p. 32-33). An August 8, 2000 MRI of the right knee demonstrated a tear of the posterior horn of the medial meniscus. *Id*. at 28. An October 2, 2000 EMG revealed: a low amplitude right saphenous sensory nerve conduction study consistent with an incomplete right saphenous sensory neuropathy; and there was no electro-physical evidence of a more proximal fomoral neuropathy, right lumbosacral radiculopathy, or a more diffuse polynucuropathy affecting the right lower limb. *Id*. at 27. On October 23, 2000, Dr. Hinton stated that Claimant's symptoms were consistent with a meniscal tear and a saphenous nerve injury. *Id*. at 25; (CX 1, p. 12). Dr. Hinton performed arthroscopic surgery on October 31, 2000, and his post-operative diagnosis was: complex tear to the medial meniscus, chondromalacia grade 2/4 of the medial femoral condyle, chrondromalacia grade 2/4 of the patella, and multiple loose body formations. (CX 2, p. 21,25).

On January 8, 2001, Dr. Hinton reported Claimant had a full range of motion, no effusion, and a well healed surgical incision. (CX 2, p. 14). Claimant did have a diffuse numbness pattern and Dr. Hinton recommended an evaluation by a neurologist for evaluation and treatment of a saphenous nerve injury. *Id*. The numbness was diffuse, meaning that it did not follow any particular nerve root dermatome pattern. (CX 1, p. 20). On January 18, 2001, Claimant reported numbness, tingling, pain, minor paralysis, right foot swelling and knee pain to Dr. Sconzert. (EX 3, p. 1). Dr. Sconzert opined Claimant had a right saphenous nerve injury secondary to trauma. *Id*.

On March 9, 2001, Dr. Hinton noted that Claimant was having problems with numbness in his foot, and he was complaining of episodes of instability, catching, and locking of his knee. (CX 2, p. 11). On June 18, 2001, Claimant again complained to Dr. Hinton of foot and ankle pain, and burning sensations due to his nerve injury. (CX 2, p. 9). Claimant demonstrated mild swelling and pain on palpation in his physical exam, and Dr. Hinton recommended Claimant have a bone scan. *Id*. at 9. The bone scan, performed on August 2, 2001, revealed increased radioniclide uptake within the right knee in multiple locations when compared to the left. (CX 2, p. 6). Reviewing the results on

August 8, 2001, Dr. Hinton remarked the findings were consistent with degenerative joint disease or with RSD. *Id*. at 5.

On June 19, 2001, Dr. Odenheimer, detected a slight limp and a subtle foot drop. (CX 3, p. 75). Dr. Odenheimer's initial impression was: leg pain, neuralgia, possible dystonia,[6] sensory disturbance, sleep disturbance, weakness, situational depression, knee pain/trauma. *Id*. On September 18, 2001, Claimant told Dr. Odenheimer that he was experiencing right low back pain when he walked and Claimant was using a cane. *Id*. at 16.

An MRI of Claimant's right knee on August 21, 2001 demonstrated: a tear of the posterior horn of the medial meniscus with extension to the superior meniscal surface, and small joint effusion, but the results were otherwise normal. (CX 2, p. 3). Dr. Hinton's impression was that Claimant suffered from arthritis in the knee and RSD. *Id*. at 2.

On November 21, 2001, Claimant reported symptoms of head aches, poor sleep, burning sensations in his right calf, spasm in the foot and toes, and pain and swelling in his right leg that was exacerbated by his functional capacity evaluation. (CX 3, p. 21). Dr. Odenheimer noted that spasms in the foot and toes were likely the result of a peripheral nerve injury. *Id*. at 22. During Claimant's examination, Dr. Odenheimer was not able to detect any foot and toe spasm, swelling in Claimant's leg, or back spasms. (CX 4, p. 12).

On March 27, 2002, Claimant presented to Dr. Odenheimer with complaints of right hip, leg. and thigh pain. (CX 3, p. 26). Significantly, Claimant's symptoms were moving up the leg suggesting Claimant's altered gait may be affecting his back. *Id*. Dr. Odenheimer's two new impressions were gait disturbances due to leg injury and sciatica secondary to gait change. *Id*. In a May 23, 2002 evaluation, Dr. Odenheimer assessed chronic pain syndrome. *Id*. at 31. In July 2002, Dr. Odenheimer assessed suspect lumbar radiculopathy possibly secondary to a gait disturbance, or to a leg injury. *Id*. at 33.

Because Claimant did not have a MRI of his lumbar spine, Dr. Odenheimer was unable to reach a definitive diagnosis with regard to the cause of Claimant's foot drop. (CX 3, p. 37). Regarding Dr. Hinton's assessment of RSD, Dr. Odenheimer explained it was a difficult entity to confirm and non-specific in may aspects. (CX 3, p. 39). While Dr. Odenheimer did not feel comfortable with diagnosing Claimant with RSD, Dr. Odenheimer was confident that Claimant had complex regional pain syndrome. (CX 3, p. 39; CX 4, p. 27).

[6] On October 24, 2001, Dr. Odenheimer no longer felt that dystonia was a problem. (CX 3, p. 20).

Accordingly, I find that the nature of Claimant's injury is status-post surgical repair to the medial meniscus, saphenous nerve injury, degenerative joint disease in the right knee, complex regional pain syndrome, foot drop,[7] and back pain suspect of lumbar radiculopathy.

D(2) Extent of Claimant's Injury

On July 17, 2000, Dr. Cohen evaluated Claimant, opined his symptoms outweighed his signs, and he felt that Claimant could return to light duty work. (CX 2, p. 32-33). Further diagnostic studies, however, necessitated arthroscopic surgery, and Dr. Hinton performed that operation on October 31, 2000. (CX 2, p. 21).

On January 8, 2001, Dr. Hinton reevaluated Claimant's knee and opined that Claimant had a fifteen percent permanent impairment rating to the right lower extremity and a seven percent impairment rating to the body as a whole. (CX 2, p. 37-38). Dr. Hinton referred Claimant to Dr. A. Sconzert to treat Claimant for a saphenous nerve injury, and he deferred to Dr. Sconzert on Claimant's ability to return to work. *Id*. Dr. Hinton did state that a saphenous nerve injury was not disabling. (CX 1, p. 12). Dr. Hinton related that the normal healing period for a meniscal injury ranged from three to six weeks, and Claimant's recovery period fell far outside that norm. (CX 1, p. 38-39). Dr. Sconzert remarked that in a typical case, a patient will recover from a saphenous nerve injury and have an essentially normal gait, and he fully expected Claimant to return to full functioning without any disability. *Id*. at 14-15. In a February 2, 2001 response to an inquiry by Carrier, Dr. Sconzert noted Claimant could return to work at full capacity without restrictions. (EX 2, p. 10).

On June 18, 2001, Claimant continued to complained to Dr. Hinton about foot and ankle pain as well as a burning pain due to his nerve injury. (CX 2, p. 9). When Claimant returned with the same complaints on July 27, 2001, Dr. Hinton told Claimant not to return to work until his next appointment. *Id*. at 7-8. On August 20, 2001, Dr. Hinton stated that he no longer had anything to offer Claimant from an orthopaedic standpoint. (CX 2, p. 36). On October 24, 2001, Dr. Odenheimer stated that Claimant was disabled due to his right leg injury. (CX 3, p. 70). Also in October, 2001, Claimant related that he suffered an automobile accident because he could not adequately control his right foot. *Id*. at 20.

On March 27, 2002, after Claimant presented with complaints of right hip, leg, and thigh pain that were affecting his back, Dr. Odenheimer reaffirmed that Claimant was unable to return to his previous employment. (CX 3, p. 27). Specific restrictions would in accordance with Claimant's functional capacity evaluation and the limitations set by Claimant's orthopaedist. *Id*. Based on Claimant's medications, Dr. Odenheimer did not recommend that Claimant operate any machinery or equipment. *Id*. at 29. In a May 23, 2002 evaluation, Dr. Odenheimer assessed chronic pain syndrome and reported that Claimant still could not return to his previous employment. *Id*. at 31.

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[7] Although Dr. Hinton opined that Claimant did not really have a foot drop because Claimant still had some muscle strength, the uncontroverted evidence is that Claimant had some weakness in his foot and needed to wear a foot brace.

Given Claimant's condition on July 25, 2002, he did not feel that Claimant was capable of light duty work during an eight hour day, and that disability was continuing. (CX 3, p. 35, 42). Dr. Odenheimer had not observed any symptom magnification or malingering. *Id*. at 41.

On August 12, 2002, Dr. Hinton reevaluated Claimant's permanent impairment rating and assessed a new rating of twenty percent to the leg which equated to a nine percent impairment to the whole body.[8] (CX 1, p. 38). Claimant's impairment rating had increased because he has some atrophy in his legs and his muscles were smaller. *Id*. at 44. Dr. Hinton did not assign any work restrictions regarding Claimant's knee because Claimant had no mechanical restrictions, and Dr. Hinton did not recommend further surgery. *Id*. at 44-45.

Accordingly, I find that the extent of Claimant's disability is such that he suffers from a twenty percent permanent partial impairment rating to his lower right extremity, suffers from a non-disabling saphenous nerve injury, a foot drop that limits his ability to drive, pain secondary to complex regional pain syndrome, and unspecific back problems. While Dr. Sconzert opined Claimant could return to full duty without restrictions based on his saphenous nerve injury, and while Dr. Hinton stated Claimant had fully recovered from his arthroscopic surgery with no restrictions to his knee, Dr. Odenheimer's uncontested recommendation was that Claimant could not resume his former job, operate heavy machinery or equipment based on his medications, and was not capable of working light duty eight hours a day based on Claimant's overall condition.[9]

D(3) Date of Maximum Medical Improvement

In regards to Claimant's knee surgery, Dr. Hinton related Claimant had reached maximum medical improvement with a fifteen percent permanent impairment rating to the right lower extremity and a seven percent impairment rating to the body as a whole on January 8, 2001. (CX 2, p. 37-38). Dr. Hinton related that the normal healing period for a meniscal injury ranged from three to six weeks, and Claimant's recovery period fell far outside that norm. (CX 1, p. 38-39). On August 20, 2001, Dr. Hinton stated that he had nothing further to offer Claimant from an orthopaedic standpoint. (CX 2, p. 36). Claimant, however, did have RSD and a "hot" bone scan, and to further evaluate Claimant's foot drop symptom, Dr. Hinton recommended an MRI of Claimant's lumbar spine. (CX 1, p. 31-32). On August 12, 2002, Dr. Hinton explained that Claimant's disability rating to his knee had increased to twenty percent based on some additional muscle atrophy. (CX 1, p. 38, 44). At that time Claimant had no mechanical restrictions to his knee as a result of his injury and Dr. Hinton did not recommend further surgery. *Id*.

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[8] Dr. Odenheimer declined to give a disability rating because he did not feel qualified to perform such tasks. (CX 3, p. 12).

[9] Dr. Odenheimer deferred the setting of specific work restrictions to Claimant's orthopaedist, Dr. Hinton and deferred to the results of Claimant's functional capacity exam. (CX 3, p. 27). No functional capacity exam was submitted in evidence, and Dr. Hinton stated the Claimant's remaining problems were best treated by a neurologist because he had nothing more to offer Claimant from an orthopaedic standpoint. (CX 1, p. 44-45, 56).

Outside of Claimant's arthroscopic surgery and recovery period, however, Dr. Hinton declined to assess a date for maximum medical improvement. Given the fact that Claimant did not have a compete neurological work up, a lumber MRI, or pain management treatment, Dr. Hinton opined Claimant had not reached maximum medical improvement with regards to his right lower extremity. (CX 1, p. 56). A neurologist should make the determination if Claimant's lower extremity had reached maximum medical improvement after the appropriate work-up. *Id*. at 56.

Dr. Odenheimer, Claimant's neurologist opined that assessing a date for maximum medical improvement was impossible until he could determine whether Claimant's back was a contributing factor to his problems, and that could not occur until Employer authorized a lumbar MRI. (CX 3, p. 42).

Regarding his remark in February, 2002, to Carrier's representative that Claimant had reached maximum medical improvement, Dr. Odenheimer stated it was a premature statement and made in connection with referring Claimant to vocational rehabilitation. (CX 3, p. 43). Specifically, Carrier asked Dr. Odenheimer: "Is it your opinion that Mr. Booker has reached MMI and can now be assessed for job placement based on the restrictions and guidelines noted in the FCE?" *Id*. at 59. In a handwritten note, Dr. Odenheimer replied: "I think this is probably the case." *Id*. Dr. Odenheimer believed Claimant's foot drop was likely permanent, he did not know if Claimant had the potential for improvement, and did not know whether his physical restrictions were permanent. (CX 4, p. 17). Claimant may be at maximum medical improvement, but if he had a back problem contributing to his current limitation, a date for maximum medical improvement may not come for a few years. *Id*. at 17-18. Based on his records, Dr. Odenheimer opined that Claimant had reached a plateau with respect to improvement of his condition and his course of treatment was basically static. *Id*. at 18.

In a February 2, 2001 response to an inquiry by Carrier, Dr. Sconzert noted Claimant could return to work at full capacity without restrictions. (EX 2, p. 10). Dr. Sconzert did not know when Claimant would reach maximum medical improvement. *Id*. Accordingly, I find that Claimant reached maximum improvement with regards to Dr. Hinton's arthroscopic knee surgery on January 8, 2001. Although Claimant had reached a plateau in Dr. Odenheimer's treatment and Claimant's condition is currently static, I find that pursuant to the opinion of Dr. Odenheimer, Claimant is not a maximum medical improvement until Dr. Odenheimer can ascertain whether Claimant's lumbar spine is a contributing factor to Claimant's symptoms and whether medical treatment will improve Claimant's condition based on the diagnostic testing.

F. Conclusion

Claimant suffers from status-post surgical repair to the medial meniscus, saphenous nerve injury, degenerative joint disease in the right knee, complex regional pain syndrome, foot drop, and back pain suspect of lumbar radiculopathy that are related to his July 7, 2000 workplace accident. To evaluate and treat those conditions, Claimant is entitled to a lumbar MRI and an updated EMG. Additionally, Dr. Odenheimer's prescription for handicap hand control for Claimant's automobile is a reasonable and necessary accommodation for Claimant's foot drop disability. The nature of

Claimant's work related injury is such that Claimant cannot resume his former job, and is currently unable to perform light duty work on an eight hour a day basis. Although Claimant has likely reached maximum medical improvement, such a determination cannot be made until Claimant's treating physicians are able to assess a lumbar MRI and an updated EMG. Because Claimant cannot resume his former job, and because Employer did not show any suitable alternative employment, Claimant is temporarily and totally disabled.

G. Interest

Although not specifically authorized in the Act, it has been an accepted practice that interest at the rate of six per cent per annum is assessed on all past due compensation payments. *Avallone v. Todd Shipyards Corp.*, 10 BRBS 724 (1974). The Benefits Review Board and the Federal Courts have previously upheld interest awards on past due benefits to insure that the employee receives the full amount of compensation due. *Watkins v. Newport News Shipbuilding & Dry Dock Co., aff'd in pertinent part and rev'd on other grounds, sub nom. Newport News v. Director, OWCP*, 594 F.2d 986 (4th Cir. 1979). The Board concluded that inflationary trends in our economy have rendered a fixed six per cent rate no longer appropriate to further the purpose of making Claimant whole, and held that "...the fixed per cent rate should be replaced by the rate employed by the United States District Courts under 28 U.S.C. § 1961 (1982). This order incorporates by reference this statute and provides for its specific administrative application by the District Director. *See Grant v. Portland Stevedoring Company, et al.*, 17 BRBS 20 (1985). The appropriate rate shall be determined as of the filing date of this Decision and Order with the District Director.

H. Attorney Fees

No award of attorney's fees for services to the Claimant is made herein since no application for fees has been made by the Claimant's counsel. Counsel is hereby allowed thirty (30) days from the date of service of this decision to submit an application for attorney's fees. A service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have twenty (20) days following the receipt of such application within which to file any objections thereto. The Act prohibits the charging of a fee in the absence of an approved application.

V. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I enter the following Order:

1. Employer shall pay to Claimant temporary total disability compensation pursuant to 33 U.S.C. § 908(b) of the Act from July 8, 2000 and continuing, based on an average weekly wage of $498.90, and a corresponding compensation rate of $332.60.

2. Employer shall be entitled to a credit for all wages and compensation paid to Claimant after July 7, 2000.

3. Employer shall provide to Claimant all future reasonable medical care and treatment arising out of his work-related injuries pursuant to Section 7(a) of the Act, including, but not limited to, a lumbar MRI, an updated EMG, and handicap hand control devices for Claimant's automobile.

4. Employer shall pay Claimant interest on accrued unpaid compensation benefits. The applicable rate of interest shall be calculated immediately prior to the date of judgment in accordance with 28 U.S.C. §1961.

5. Claimant's counsel shall have thirty (30) days to file a fully supported fee application with the Office of Administrative Law Judges, serving a copy thereof on Claimant and opposing counsel who shall have twenty (20) days to file any objection thereto.

A

CLEMENT J. KENNINGTON
Administrative Law Judge